ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

NOTICE OF RULE MAKING

TO: **Health Care Providers – Area Health Education Centers (AHECs), Ambulatory Surgical Center, Arkansas Department of Health (ADH), ARKids First-B, Certified Nurse-Midwife, Critical Access Hospital, Dental, Home Health, End-Stage Renal Disease, Family Planning, Federally Qualified Health Clinic, Hospital, Independent Radiology, Nurse Practitioner, Oral Surgeon, Physician, Private Duty Nursing, Prosthetics**

DATE: **March 15, 2013**

SUBJECT: **2013 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion**

I. General Information

A review of the 2013 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated Healthcare Common Procedural Coding System Level II (HCPCS) procedure codes on claims with dates of service on and after March 15, 2013. Drug procedure codes require National Drug Code (NDC) billing protocol. Drug procedure codes that represent radiopharmaceuticals, vaccines, and allergen immunotherapy are exempt from the NDC billing protocol.

Procedure codes that are identified as deletions in 2013 HCPCS Level II will become non-payable for dates of service on and after March 15, 2013.

Please note: The Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2013 CPT and HCPCS conversions.

II. 2013 HCPCS Payable Procedure Codes Tables Information

Procedure codes are in separate tables. Tables are created for each affected provider type (i.e., prosthetics, home health, etc.).

The tables of payable procedure codes for all affected programs are designed with eight columns of information. All columns may not be applicable for each covered program, but are devised for ease of reference.

Please note: An asterisk indicates that the procedure code requires a paper claim.

1. The first column of the list contains the HCPCS procedure codes. The procedure code may be on multiple lines on the table, depending on the applicable modifier(s) based on the service performed.

2. The second column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.

3. The third column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years.

4. Certain procedure codes are covered only when the primary diagnosis is covered within a specific ICD-9-CM diagnosis range. This information is used, for example, by physicians and hospitals. The fourth column, for all affected programs, indicates the beginning and ending range of ICD-9-CM diagnoses for which a procedure code may be used, (i.e., 053.0 through 054.9).

5. The fifth column contains information about the diagnosis list for which a procedure code may be used. (See Section V of this notice for more information about diagnosis range and lists.)

6. The sixth column indicates whether a procedure is subject to medical review before payment. The column is titled "Review." The word "Yes" or "No" in the column indicates whether a review is necessary or not. Providers should consult their program manual to obtain the information that is needed for a review.

7. The seventh column shows procedure codes that require prior authorization (PA) before the service may be provided. The column is titled "PA". The word "Yes" or "No" in the column indicates if a procedure code requires prior authorization. Providers should consult their program manual to ascertain what information should be provided for the prior authorization process.

8. The eighth column indicates a procedure code requires a prior approval letter from the Arkansas Medicaid Medical Director for Clinical Affairs for the Division of Medical Services. The word "Yes" or "No" in the column indicates if a procedure code requires a prior approval letter.

III. Acquisition of Prior Approval Letter

A prior approval letter, when required, must be attached to a paper claim when it is filed. Providers must obtain prior approval in accordance with the following procedures for special pharmacy, therapeutic agents, and treatments:

A. Process for Acquisition: Before treatment begins, the Medical Director for Clinical Affairs in the Division of Medical Services (DMS) must approve any drug, therapeutic agent, or treatment not listed as covered in a provider manual or in official DMS correspondence. This requirement also applies to any drug, therapeutic agent, or treatment with a prior approval letter indicated for coverage in a provider manual or official DMS correspondence.

B. The Medical Director for Clinical Affairs' review is necessary to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.

1. The provider must submit a history and physical examination with the treatment plan before beginning any treatment.

2. The provider will be notified by mail of the DMS Medical Director for Clinical Affairs' decision. No prior authorization number is assigned if the request is approved, but a prior approval letter is issued and must be attached to each paper claim submission.

   Any change in approved treatment requires resubmission and a new prior approval letter.

3. Requests for a prior approval letter must be addressed to the attention of the Medical Director for Clinical Affairs. Contact the Medical Director for Clinical Affairs' office for any additional coverage information and instructions.

Mailing address: Attention: Medical Director for Clinical Affairs Division of Medical Services AR Department of Human Services P.O. Box 1437, Slot S412 Little Rock, AR 72203-1437	Fax: 501-682-8013 Phone: 501-682-9868

IV. Process for Obtaining Prior Authorization

When obtaining a prior authorization from the Arkansas Foundation for Medical Care, please send your request to the following:

In-state and out-of-state toll free for inpatient reviews, prior authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	http://review.afmc.org/MedicaidReview/iEXCHANGE%c2%ae.aspx
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	1000 Fianna Way Fort Smith, AR 72919-9008
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

V. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. Diagnosis list 003 is specified below. For any other diagnosis restrictions, reference the table for each individual program.

Diagnosis List 003

042
140.0-209.36
209.70 through 209.75
209.79
230.0 through 238.9
511.81
V58.11 through V58.12
V87.41

VI. HCPCS Lab and Molecular Pathology Procedure Codes

Molecular Pathology procedure codes, including Healthcare Common Procedural Coding System Level II (HCPCS) procedure code **G0452** requires prior authorization (PA). Providers are to acquire prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from Arkansas Foundation for Medical Care (AFMC) before or after the procedure is performed as long as it is acquired within the 365-day filing deadline. Providers of Molecular Pathology procedures may submit molecular pathology requests and medical record documentation to AFMC via mail, fax, or electronically through a web portal. See additional contact information for AFMC in Section IV of this notice.

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services (form DMS-841) and the attachment of all pertinent clinical documentation needed to justify the procedure. If the request is approved, a prior authorization number will be assigned, and the provider will receive notification of the approval in writing by mail. If the request does not meet the medical necessity criteria and is denied, the requesting provider will receive notification of the denial in writing by mail. Reconsideration is allowed if new or additional information is received by AFMC within 30 days of the initial denial. A sample copy of form DMS-841 is attached. This form may be found in Section V of the provider manual. Copies may be made of this form. The enclosed form is for informational purposes only. **Please do not complete the enclosed form unless you are submitting a Molecular Pathology PA request.**

HCPCS procedure code **G0452** will be used for coding the Interpretation and Report of 2013 Molecular Pathology codes that allow separate Interpretation and Report. The prior authorization request for **G0452** should be submitted with the Arkansas Medicaid Request for Molecular Pathology Laboratory Services (form DMS-841). When possible, prior authorization should be obtained at the same time as the prior authorization for the CPT Molecular Pathology code. The prior authorization request for **G0452** must also include the CPT Molecular Pathology procedure code for which the interpretation and report is to be provided. **G0452** must be billed on a red line CMS-1500 paper claim with CPT Molecular Pathology Code(s) also specified for which the Interpretation and Report was performed. The claim form should list the prior authorization number and the invoice must be attached that reflects the cost to the provider for performing the interpretation and report of the test.

VII. HCPCS Procedure Codes Payable to Ambulatory Surgical Centers (ASCs)

The following information is related to procedure codes payable to ASC providers. Claims that require attachments (such as op-reports and prior approval letters) must be billed on a paper claim. See Section III of this notice for information on requesting a prior approval letter. See Section V of this notice for ICD-9-CM diagnosis codes contained in diagnosis list 003.

An asterisk (*) after the procedure code denotes the requirement of a paper claim.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9733	**No**	**No**	**No**	**No**	**No**	**No**	**No**
J0178*	**No**	**18y & up**	**362.52**	**No**	**Yes**	**No**	**Yes**
	Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.						
J1050	**No**	**10y & up**	**No**	**No**	**No**	**No**	**No**
	J1050 is covered for therapeutic and family planning services for females only. When billed for family planning, an ICD-9 family planning diagnosis is required. Relative to post occlusion by placement of permanent implants; procedure codes **J1050**, **11976** and **58301** are payable family planning services for non-sterile females only. All visits related to post-**58565** services during the six months following the procedure are included in the allowable fee for the **58565** "procedure". All facility fees for **J1050** are bundled under the surgical procedure code if performed on the same date of service.						
J1741	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**
Q2034	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**

VIII. HCPCS Procedure Codes Payable to ARKids-First B

The following information is related to procedure codes payable in the ARKids-First B program.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A4435	**No**	**0-18y**	**No**	**No**	**No**	**No**	**No**
E0670	**EP**	**0-18y**	**No**	**No**	**No**	**No**	**No**
L8605	**No**	**18y only**	**787.60**	**No**	**No**	**No**	**No**

IX. Dental

The following 2013 ADA Dental codes will no longer be payable: **D1203** and **D1204**. These codes will be replaced by **D1208**.

The following ADA Dental procedure codes **are not covered** by Arkansas Medicaid.

D0190	D0191	D0364	D0365	D0366	D0367	D0368
D0369	D0370	D0371	D0380	D0381	D0382	D0383
D0384	D0385	D0386	D0391	D2929	D2981	D2982
D2983	D2990	D4212	D4277	D4278	D6051	D6101
D6102	D6103	D6104	D7921	D7952	D9975	

X. HCPCS Procedure Codes Payable to Certified Nurse-Midwife Providers

The following information is related to procedure codes payable to Certified Nurse-Midwife providers.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	△	**10y & up**	**No**	**No**	**No**	**No**	**No**

△**J1050** is covered for therapeutic and family planning services for females only. When billed for family planning, an FP modifier and an ICD-9 family planning diagnosis are required.

XI. HCPCS Procedure Codes Payable to End-Stage Renal Disease Providers

The following information is related to procedure codes payable to End-Stage Renal Disease providers.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7527	**No**	**18y & up**	**V42.0**	**No**	**No**	**No**	**No**

XII. HCPCS Procedure Codes Payable to the Federally Qualified Health Clinic

The following information is related to procedure codes payable to Federally Qualified Health Clinic providers.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	△	**10y & up**	**No**	**No**	**No**	**No**	**No**

△**J1050** is covered for therapeutic and family planning services for females only. When billed for family planning, an FP modifier and an ICD-9 family planning diagnosis are required.

Relative to post occlusion by placement of permanent implants; procedure codes **J1050**, **11976** and **58301** are payable family planning services for non-sterile females only. All visits related to post-**58565** services during the six months following the procedure are included in the allowable fee for the **58565** "procedure".

XIII. HCPCS Procedure Codes Payable to Home Health Providers

The following information is related to procedure codes payable to Home Health providers.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A4435	**No**	**No**	**No**	**No**	**No**	**No**	**No**
L8605	**EP**	**18y-20y**	**787.60**	**No**	**No**	**No**	**No**
L8605	**No**	**21y & up**	**787.60**	**No**	**No**	**No**	**No**

XIV. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to Hospital providers. Claims that require attachments (such as op-reports and prior approval letters) must be billed on a paper claim. See Section III of this notice for information on requesting a prior approval letter. See Section V of this notice for ICD-9-CM diagnosis codes contained in diagnosis list 003.

An asterisk (*) after the procedure code denotes the requirement of a paper claim.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9586	**No**	**18y & up**	**331.0-332.1**	**No**	**No**	**No**	**No**
C9292	**No**	**18y & up**	**174.0 175.9**	**No**	**No**	**No**	**No**
C9294*	**No**	**18y & up**	**272.7**	**No**	**Yes**	**No**	**Yes**

A complete medical exam with history is required and must be submitted with a yearly evaluation by a geneticist. Prognosis should be documented as well as all prior treatments. If prior treatment is imiglucerase, the dose and outcome of treatment should be included.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9295	**No**	**18y & up**	**203.00-203.02**	**No**	**No**	**No**	**No**
C9296*	**No**	**18y & up**	**153.0-154.8**	**No**	**Yes**	**No**	**Yes**
	This procedure code is used in combination with 5-fluorouracil, leucovorin and irinotecan – (FOLFIRI) in patients with metastatic colorectal cancer (mCRC) that is resistant to or has progressed following an oxaliplatin-containing regiment. A complete history and physical exam must be sent with all previous treatments noted. Hemorrhage, gastrointestinal perforation and compromised wound healing are all complications of this procedure code and should be evaluated.						
C9733	**No**	**No**	**No**	**No**	**No**	**No**	**No**
J0178*	**No**	**18y & up**	**362.52**	**No**	**Yes**	**No**	**Yes**
	Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.						
J0485	**No**	**18y & up**	**V42.0**	**No**	**No**	**No**	**No**
J0716	**No**	**No**	**989.5**	**No**	**No**	**No**	**No**
J1050	**No**	**10y & up**	**No**	**No**	**No**	**No**	**No**
	J1050 is covered for therapeutic and family planning services for females only. When billed for family planning, an ICD-9 family planning diagnosis is required. Relative to post occlusion by placement of permanent implants; procedure codes **J1050**, **11976** and **58301** are payable family planning services for non-sterile females only. All visits related to post-**58565** services during the six months following the procedure are included in the allowable fee for the **58565** "procedure". All facility fees for **J1050** are bundled under the surgical procedure code if performed on the same date of service.						

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1741	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**
J7178	**No**	**No**	**286.3**	**No**	**No**	**No**	**No**
J7527	**No**	**18y & up**	**V42.0**	**No**	**No**	**No**	**No**
J9002	**No**	**18y & up**	**No**	**List 003**	**No**	**No**	**No**
J9019*	**No**	**2y-18y**	**No**	**No**	**Yes**	**No**	**Yes**
J9042*	**No**	**18y & up**	**200.60-200.68, 201.00-201.98**	**No**	**Yes**	**No**	**Yes**
		Adcetris - After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regiments in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, ICD-9 diagnosis 200.6, after failure of at least one prior multi-agent chemotherapy regiment. Documentation of above criteria must be submitted with current history and physical exam for a Prior Approval letter from the Medical Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.					
Q2034	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**
Q2049	**No**	**18y & up**	**No**	**List 003**	**No**	**No**	**No**
Q9969	**No**	**No**	**No**	**No**	**No**	**No**	**No**

XV. HCPCS Procedure Codes Payable to Independent Radiology

The following information is related to procedure codes payable to Independent Radiology providers.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9586	**No**	**18y & up**	**331.0-332.1**	**No**	**No**	**No**	**No**
Q9969	**No**	**No**	**No**	**No**	**No**	**No**	**No**

XVI. HCPCS Procedure Codes Payable to Nurse Practitioners

The following information is related to procedure codes payable to Nurse Practitioner providers.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	△	**10y & up**	**No**	**No**	**No**	**No**	**No**
	△**J1050** is covered for therapeutic and family planning services for females only. When billed for family planning, an FP modifier and an ICD-9 family planning diagnosis are required.						

XVII. Oral Surgeons

The following 2013 ADA Dental codes will no longer be payable: **D1203** and **D1204.** These codes will be replaced by **D1208.**

The following ADA Dental procedure codes **are not covered** by Arkansas Medicaid.

D0190	D0191	D0364	D0365	D0366	D0367	D0368
D0369	D0370	D0371	D0380	D0381	D0382	D0383
D0384	D0385	D0386	D0391	D2929	D2981	D2982
D2983	D2990	D4212	D4277	D4278	D6051	D6101
D6102	D6103	D6104	D7921	D7952	D9975	

XVIII. HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs)

The following information is related to procedure codes payable to Physicians and AHECs. Claims that require attachments (such as operative reports and prior approval letters) must be billed on a paper claim. See Section III of this notice for information on requesting a prior approval letter. See Section V of this notice for the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes contained in diagnosis list 003.

An asterisk (*) after the procedure code denotes the requirement of a paper claim.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9586	**No**	**18y & up**	**331.0-332.1**	**No**	**No**	**No**	**No**

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9292	**No**	**18y & up**	**174.0 175.9**	**No**	**No**	**No**	**No**
C9294*	**No**	**18y & up**	**272.7**	**No**	**Yes**	**No**	**Yes**
	A complete medical exam with history is required and must be submitted with a yearly evaluation by a geneticist. Prognosis should be documented as well as all prior treatments. If prior treatment is imiglucerase, the dose and outcome of treatment should be included.						
C9295	**No**	**18y & up**	**203.00-203.02**	**No**	**No**	**No**	**No**
C9296*	**No**	**18y & up**	**153.0-154.8**	**No**	**Yes**	**No**	**Yes**
	This procedure code is used in combination with 5-fluorouracil, leucovorin and irinotecan – (FOLFIRI) in patients with metastatic colorectal cancer (mCRC) that is resistant to or has progressed following an oxaliplatin-containing regiment. A complete history and physical exam must be sent with all previous treatments noted. Hemorrhage, gastrointestinal perforation and compromised wound healing are all complications of this procedure code and should be evaluated.						
C9733	**No**	**No**	**No**	**No**	**No**	**No**	**No**
J0178*	**No**	**18y & up**	**362.52**	**No**	**Yes**	**No**	**Yes**
	Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.						
J0485	**No**	**18y & up**	**V42.0**	**No**	**No**	**No**	**No**
J0716	**No**	**No**	**989.5**	**No**	**No**	**No**	**No**
J1050	**△**	**10y & up**	**No**	**No**	**No**	**No**	**No**
	△J1050 is covered for therapeutic and family planning services for females only. When billed for family planning, an FP modifier and an ICD-9 family planning diagnosis are required. Relative to post occlusion by placement of permanent implants; procedure codes **J1050**, **11976** and **58301** are payable family planning services for non-sterile females only. All visits related to post-**58565** services during the six months following the procedure are included in the allowable fee for the **58565** "procedure".						
J1741	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7178	**No**	**No**	**286.3**	**No**	**No**	**No**	**No**
J7527	**No**	**18y & up**	**V42.0**	**No**	**No**	**No**	**No**
J9002	**No**	**18y & up**	**No**	**List 003**	**No**	**No**	**No**
J9019*	**No**	**2y-18y**	**No**	**No**	**Yes**	**No**	**Yes**
J9042*	**No**	**18y & up**	**200.60-200.68, 201.00-201.98**	**No**	**Yes**	**No**	**Yes**

Adcetris - After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regiments in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, ICD-9 diagnosis 200.6, after failure of at least one prior multi-agent chemotherapy regiment. Documentation of above criteria must be submitted with current history and physical exam for a Prior Approval letter from the Medical Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

Q2034	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**
Q2049	**No**	**18y & up**	**No**	**List 003**	**No**	**No**	**No**
Q9969	**No**	**No**	**No**	**No**	**No**	**No**	**No**

XIX. HCPCS Procedure Codes Payable to Private Duty Nursing

The following information is related to procedure codes payable to Private Duty Nursing providers.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A4435§	**No**	**0-20y**	**No**	**No**	**No**	**No**	**No**
A4435	**No**	**0-99**	**No**	**No**	**No**	**No**	**No**

§ **A4435** is payable for private duty nursing in the school district for ages 0-20y.

XX. HCPCS Procedure Codes Payable to Prosthetics

The following information is related to procedure codes payable to Prosthetics providers. Procedure codes in the table must be billed with appropriate modifiers. For procedure codes that require a prior authorization, the written PA request must be submitted to the Utilization Review Section of the Division of Medical Services (DMS) for wheelchairs and wheelchair related equipment and services.

For other durable medical equipment (DME), a written request must be submitted to the Arkansas Foundation for Medical Care. Please refer to your Arkansas Medicaid Prosthetics Provider Manual for details on requesting a DME prior authorization.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A4435	**No**	**No**	**No**	**No**	**No**	**No**	**No**
E0670	**No**	**21y & up**	**457.1**	**No**	**No**	**No**	**No**
E0670	**EP**	**0-20y**	**457.1**	**No**	**No**	**No**	**No**
E2378	**No**	**21y & up**	**No**	**No**	**No**	**Yes**	**No**
E2378	**EP**	**2y-20y**	**No**	**No**	**No**	**Yes**	**No**
L8605	**EP**	**18y-20y**	**787.60**	**No**	**No**	**No**	**No**
L8605	**No**	**21y & up**	**787.60**	**No**	**No**	**No**	**No**

XXI. Miscellaneous Information

A. Existing HCPCS procedure code **J1725** is payable to the following providers: AHEC, ADH, Hospitals and Physicians. See the coverage criteria listed below.

An asterisk (*) after the procedure code denotes the requirement of a paper claim.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1725	**No**	**16y & up**	**V23.41**	**No**	**No**	**No**	**No**
Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code of V23.41, “Pregnancy with history of pre-term labor”. J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.							
J1756*	**No**	**18y & up**	**285.21**	**No**	**Yes**	**No**	**Yes**

B. Existing HCPCS procedure codes **J1756** and **J2426** are payable to Hospitals and Physicians.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1725	**No**	**16y & up**	**V23.41**	**No**	**No**	**No**	**No**
	Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code of V23.41, "Pregnancy with history of pre-term labor". J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.						
J1756*	**No**	**18y & up**	**285.21**	**No**	**Yes**	**No**	**Yes**

The **J2426** diagnosis restriction has been updated to 295.00-295.95.

C. Existing procedure code **J0152** is now billable electronically as well as on paper for AHEC, Hospital, Physician, Nurse Practitioner and Transportation providers.

XXII. Non-Covered 2013 HCPCS with Elements of CPT or Other Procedure Codes

The following new 2013 HCPCS procedure codes are not payable because these services are covered by a CPT code, another HCPCS code, or a revenue code.

C9290	J1744	J2212	J7315	S1090

XXIII. Non-Covered 2013 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

C9293	G0453	G0454	G0455	G0456	G0457	G0458
G8907	G8908	G8909	G8910	G8911	G8912	G8913
G8914	G8915	G8916	G8917	G8918	G8919	G8920
G8921	G8922	G8923	G8924	G8925	G8926	G8927
G8928	G8929	G8930	G8931	G8932	G8933	G8934
G8935	G8936	G8937	G8938	G8939	G8940	G8941
G8942	G8943	G8944	G8945	G8946	G8947	G8948
G8949	G8950	G8951	G8952	G8953	G8954	G8955
G8956	G8957	G8958	G8959	G8960	G8961	G8962
G8963	G8964	G8965	G8966	G8967	G8968	G8969
G8970	G8971	G8972	G8973	G8974	G8975	G8976
G8977	G8978	G8979	G8980	G8981	G8982	G8983
G8984	G8985	G8986	G8987	G8988	G8989	G8990
G8991	G8992	G8993	G8994	G8995	G8996	G8997
G8998	G8999	G9157	G9158	G9159	G9160	G9161
G9162	G9163	G9164	G9165	G9166	G9167	G9168
G9169	G9170	G9171	G9172	G9173	G9174	G9175
G9176	G9186	J0890	L5859	L7902	Q4131	Q4132
Q4133	Q4134	Q4135	Q4136	S0353	S0354	S0596
S3721	S8930	S9110	V5281	V5282	V5283	V5284
V5285	V5286	V5287	V5288	V5289	V5290	

If you have questions regarding this notice, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

REQUEST FOR MOLECULAR PATHOLOGY LABORATORY SERVICES

Arkansas Foundation for Medical Care, Inc.
Attn: Molecular Pathology Review

P O Box 180001
Fort Smith, AR 72918-0001
Fax: (479) 649-9413

DATE: ____/____/____

Important: If all required information is not completed, the form will be returned to the provider.

(1) **PERFORMING PROVIDER NAME**	(2) **PROVIDER ID#/TAXONOMY CODE**
(3) **MAILING ADDRESS**	(4) **GROUP PROVIDER ID #** (9 digits) __ __ __ __ __ __ __ __ __
CITY **STATE** **ZIP CODE**	
(5) **PERFORMING PROVIDER SIGNATURE & CREDENTIALS**	

(6) **BENEFICIARY NAME [LAST]** **[FIRST]** **[M.I.]**		
(7) **ADDRESS** **CITY** **STATE** **ZIP CODE**		
(8) **MEDICAID BENEFICIARY ID** (10 digits) __ __ __ __ __ __ __ __ __ __	(9) **DOB MM/DD/YY** ____/____/_____	**SEX** _____

To file a Request for Molecular Pathology Laboratory Services, the following information is required:

							Request Disposition *Completed By AFMC*		
(10) SERVICE FROM DATE	**(11) SERVICE TO DATE**	(12) DIAGNOSIS CODE	*(13) DIAGNOSIS CODE DESCRIPTION*	(14) PROCEDURE CODE	(15) *PROCEDURE CODE DESCRIPTION*	(16) UNITS	***DECISION*** **APPROVED**	**DENIED**	**DATE OF REVIEW**

Molecular Pathology Request # _____
Completed by AFMC

Note: If applicable, attach copies of Medical Records/Supporting Documentation substantiating the medical necessity of requested services/procedures.
[Instructions for requesting molecular pathology and completion of this form are included on the reverse side of this form.]
Comments:

Requirements for Requests for Molecular Pathology Laboratory Services

Procedural Policy

To reduce delays in processing requests and to avoid returning requests due to incomplete and/or lack of documentation, the following procedures must be followed.

I. Requests for molecular pathology laboratory services must be requested and a prior authorization received prior to billing the claims.

II. The Request for Molecular Pathology Laboratory Services (Form DMS-841) must accompany the supporting clinical record when submitting a paper request.

III. Molecular Pathology Laboratory Services requests will be denied if received after the timely filing time frame (12 months beyond the date of service).

IV. AFMC Molecular Pathology Laboratory requests will be considered if all of the following documentation is received with the request.

A. All fields of form DMS-841 must be correctly completed by entering the following information:

(1) Enter performing provider's name.
(2) Enter the provider ID # and taxonomy code of performing provider.
(3) Enter the address the provider will use to receive correspondence regarding this request.
(4) If the provider is a member of a group, enter the group provider ID #.
(5) Performing provider's signature and credentials must be entered in this field.
(6) Enter the beneficiary's full name.
(7) Enter the beneficiary's complete address.
(8) Enter the beneficiary's Medicaid ID #.
(9) Enter the beneficiary's date of birth and sex.
(10) Enter the service from date.
(11) Enter the service to date.
(12) Enter the diagnosis code.
(13) Enter the diagnosis code description.
(14) Enter the procedure code and applicable modifier(s). (If there are more than 8 procedures, additional procedures must be added to a separate, completed form.)
(15) Enter the procedure code description.
(16) Enter the number of units.

B. Clinical records must:

1. Be legible and include records supporting the specific request.
2. Be signed by the performing provider.

C. Laboratory reports must include:

1. Clinical indication for lab
2. Signed orders for laboratory

D. Requests for reconsideration must be received within 30 calendar days of AFMC denial - only one reconsideration will be allowed.

E. AFMC reserves the right to request further clinical documentation as deemed necessary to complete a medical review.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

NOTICE OF RULE MAKING

TO: **Health Care Providers – Area Health Education Centers (AHECs), Arkansas Department of Health, Ambulatory Surgical Center, ARKids First-B, Child Health Management Services (CHMS), Critical Access Hospital, Dental, End Stage Renal Disease, Federally Qualified Health Center, Hospital, Independent Laboratory, Independent Radiology, Licensed Mental Health Practitioners, Nurse Practitioner, Oral Surgeons, Pharmacy, Physician, Rehabilitative Services for Persons with Mental Illness (RSPMI), Rehabilitative Services for Youth and Children (RSYC), Rural Health Clinic, School-Based Mental Health Services (SBMH)**

DATE: **March 15, 2013**

SUBJECT: **2013 Current Procedure Terminology (CPT®) Code Conversion**

I. General Information

A review of the 2013 Current Procedural Terminology (CPT®) procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT® 2013 procedure codes for dates of service on and after March 15, 2013.

Procedure codes that are identified as deletions in CPT® 2013 (Appendix B) are **non-payable** for dates of service on and after March 15, 2013.

For the benefit of those programs impacted by the conversions, the Arkansas Medicaid Web site fee schedules will be updated soon after the implementation of the 2013 CPT® and Healthcare Common Procedural Coding System Level II (HCPCS) conversions.

II. Process for Obtaining Prior Authorization

A. When obtaining a prior authorization from the Arkansas Foundation for Medical Care, please send your request to the following:

In-state and out-of-state toll free for inpatient reviews, prior authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	http://review.afmc.org/MedicaidReview/iEXCHANGE%c2%ae.aspx
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	1000 Fianna Way Fort Smith, AR 72919-9008
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

B. When obtaining a prior authorization from ValueOptions, please send your request to the following:

Clinical Department	(877) 821-0566
Fax	(877) 823-5691
EDI Help Desk	(888) 247-9311 – ValueOptions IT help
Mailing Address:	ValueOptions 1401 W. Capitol Ave., Suite 330 Little Rock, AR 72201 http://arkansas.valueoptions.com

III. Non-Covered 2013 CPT® Procedure Codes

A. Effective for dates of service on and after March 15, 2013, the following CPT® procedure codes are non-covered.

90653	90685	90686	90687	90688	90739	90785
90863	99485	99486	99487	99488	99489	99495
99496						

B. All 2013 CPT® procedure codes listed in **Category II** and **Category III** are not recognized by Arkansas Medicaid; therefore, they are non-covered.

C. The following new 2013 CPT® procedure codes are not payable to Outpatient Hospitals because these services are covered by another CPT® procedure code, another HCPCS code or a revenue code.

31649	31651	33367	33368	33369	36227	36228

D. The following new 2013 CPT® procedure codes are not payable to Ambulatory Surgical Centers because these services are covered by another CPT® procedure code, another HCPCS code or a revenue code.

31649	31651	33367	33368	33369	36227	36228

IV. CPT® Lab and Molecular Pathology Procedure Codes

Molecular Pathology procedure codes in this section listed in points A, B, and C below, require prior authorization (PA). Providers are to acquire prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from Arkansas Foundation for Medical Care (AFMC) before or after the procedure is performed as long as it is acquired within the 365-day filing deadline. Providers of these procedures may submit molecular pathology requests and medical record documentation to AFMC via mail, fax, or electronically through a web portal. See additional contact information for AFMC in Section II of this notice.

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services (form DMS-841) and the attachment of all pertinent clinical documentation needed to justify the procedure. If the request is approved, a prior authorization number will be assigned and the provider will receive notification of the approval in writing by mail. If the request does not meet the medical necessity criteria and is denied, the requesting provider will receive notification of the denial in writing by mail. Reconsideration is allowed if new or additional information is received by AFMC within 30 days of the initial denial. A sample copy of form DMS-841 is attached. This form may be found in Section V of the provider manual. Copies may be made of this form. The enclosed form is for informational purposes only. **Please do not complete the enclosed form unless you are submitting a Molecular Pathology PA request.**

Molecular Pathology procedure codes must be submitted on a red line paper claim form with the PA listed on the claim, and the itemized invoice attached that supports the charges for the test billed.

A. The following 2013 CPT® Molecular Pathology codes require a prior authorization from the Arkansas Foundation for Medical Care payable effective March 15, 2013.

81161	81201	81202	81203	81235	81252	81253
81254	81321	81322	81323	81324	81325	81326

B. **Healthcare Common Procedural Coding System Level II (HCPCS)** procedure code **G0452** will be used for coding the Interpretation and Report of 2013 Molecular Pathology codes that allow separate Interpretation and Report and requires prior authorization from AFMC. The prior authorization request for **G0452** should be submitted using the Arkansas Medicaid Request for Molecular Pathology Laboratory Services (form DMS-841). When possible, prior authorization should be obtained at the same time as the prior authorization for the CPT Molecular Pathology code. The prior authorization request for **G0452** must include the CPT Molecular Pathology procedure code for which the interpretation is to be provided. **G0452** must be billed on a red line CMS-1500 paper claim form with CPT Molecular Pathology Code(s) specified for which the Interpretation and Report was performed, the prior authorization number listed on the claim, and the itemized invoice attached that supports the charges for the interpretation and report billed.

C. The following 2012 Molecular Pathology CPT® procedure codes require a prior authorization from Arkansas Foundation for Medical Care payable effective March 15, 2013.

81200	81205	81206	81207	81208	81209	81210
81211	81212	81213	81214	81215	81216	81217
81220	81221	81222	81223	81224	81225	81226
81227	81228	81229	81240	81241	81242	81243
81244	81245	81250	81251	81255	81256	81257
81260	81261	81262	81263	81264	81265	81266
81267	81268	81270	81275	81280	81281	81282
81290	81291	81292	81293	81294	81295	81296
81297	81298	81299	81300	81301	81302	81303
81304	81310	81315	81316	81317	81318	81319
81330	81331	81332	81340	81341	81342	81350
81355	81370	81371	81372	81373	81374	81375
81376	81377	81378	81379	81380	81381	81382
81483	81400	81401	81402	81403	81404	81405
81406	81407	81408				

D. The 2013 CPT® Laboratory codes with special coverage criteria include the following:

Procedure Code	Age Restriction in Years	Diagnosis	Special Instructions
81479	No		Requires paper billing with attachments that describe and justify the service represented by this procedure.
81500 81503	18y & up	042 140.0-209.30 209.31-209.36 209.70-209.75 209.79 230.0-238.9 511.81 V58.11-V58.12 or V87.41	This code is restricted to female beneficiaries. Requires paper billing that describes and justifies the procedure.
81508 81509 81510 81511 81512		Diagnosis must indicate a **current** condition of pregnancy	

Procedure Code	Age Restriction in Years	Diagnosis	Special Instructions
81599			For consideration of claims with unlisted procedure codes, such as **81599**: The provider must submit a paper claim that includes a description of the service being represented by the unlisted procedure code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity. All other billing requirements must be met in order for payment to be approved.
82777	18y & up	428.0	
86828 86829 86830 86831 86832 86833 86834 86835		V42.0- V42.9	

V. Ambulatory Surgical Centers

The following 2013 CPT® procedure codes are payable to Ambulatory Surgical Centers.

22586	23473	23474	24370	24371	31647	31648
31649	31651	31660	31661	32554	32555	32556
32557	32701	33361	33390	33991	33992	33993
36221	36222	36223	36224	36225	36226	37197
37211	37212	37213	37214	43206	43252	44705
52287*	64615	78012	78013	78014	78071	78072
86711	86828	86829	86830	86831	86832	86833
86834	86835	87631	87632	87633	87910	87912
88375**	91112	93653	93654	93655	93656	93657
95782***	95783***	95907	95908	95909	95910	95911
95912	95913	95924	95940	95941	95943	

*****CPT® procedure code **52287** is covered for spinal cord injury and Multiple Sclerosis.

******CPT® procedure code **88375** must be billed with a diagnosis of 042, 140.0-209.30, 209.31-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81, V58.11-V58.12 or V87.41.

*******CPT® procedure codes **95782** and **95783** have an age restriction of six years or younger.

VI. Transplant Services

CPT® procedure code 38243 is payable with prior approval for a bone marrow transplant.

The attending physician must request approval for this procedure. Refer to Section 261.220 of the Physician manual.

VII. Child Health Management Services

The following 2013 CPT® procedure codes are payable in the Child Health Management program.

⁂(…)This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

A. Diagnosis and Evaluation Procedure Codes

The following diagnosis/evaluation procedure codes are limited to two (2) diagnosis and evaluation encounters per state fiscal year (July 1 through June 30). If additional diagnosis and evaluation procedures are required, the CHMS provider must request an extension of benefits.

2013 Deleted Code	2013 Replacement Code	Required Modifier(s)	Description
90801	90791	U9	⁂(Diagnostic evaluation/review of records (1 unit = 15 minutes), maximum of 3 units; limited to 6 units per state fiscal year)
90805	90833	U9	⁂(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face to face with the patient with medical evaluation and management services)
90807	90836	U9	⁂(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face to face with the patient with medical evaluation and management services)
90809	90838	U9	⁂(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face to face with the patient with medical evaluation and management services)

B. Treatment Procedure Codes

The following treatment procedures are payable for services included in the child's treatment plan. Prior authorization is required for *all* CHMS treatment procedures. See Section 240.000 of the Child Health Management manual for prior authorization requirements. See Glossary - Section IV - for definitions of "individual" and "group" as they relate to therapy services.

2013 Deleted Code	2013 Replacement Code	Required Modifier(s)	Description
90804	90832	U9	⁂(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face to face with the patient)
90806	90834	U9	⁂(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face to face with the patient)
90808	90837	U9	⁂(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face to face with the patient)

C. CHMS Procedure Codes – Foster Care Program

Refer to Section 202.000 of the Child Health Management Services manual for Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children.

The following procedure codes are to be used for the mandatory comprehensive health assessments of children entering the Foster Care Program. These procedures *do not* require prior authorization.

2013 Deleted Code	Required Modifier(s)	2013 Replacement Code	Required Modifier(s)	Description
90801	U1	90791	U1 U9	⁂(Diagnostic Interview, includes evaluation and reports (1 unit = 15 minutes), maximum of 8 units)

VIII. Independent Radiology

The following 2013 CPT® procedure codes are payable to Independent Radiology providers.

78012	78013	78014	78071	78072

IX. Licensed Mental Health Practitioners (LMHP)

The following 2013 CPT® procedure codes are payable to Licensed Mental Health Practitioners.

2013 Deleted Code	2013 Replacement Code	Required Modifier(s)
90801	90791	U1

X. Oral Surgeons

2013 CPT® procedure code **43206** is payable to Oral Surgeons.

XI. Rehabilitative Services for Youth and Children (RSYC)

The following 2013 CPT® procedure codes are payable to Rehabilitative Services for Youth and Children (RSYC) providers.

The column titled "PA" shows procedure codes that require prior authorization (PA) before the service may be provided. The word "Yes" or "No" in the column indicates if a procedure code requires prior authorization. Please see Section II of this notice for information on requesting prior authorization from ValueOptions.

Program	2013 Deleted Code	Required Modifier(s)	2013 Replacement Code	Required Modifier(s)	PA
Division of Youth Services	90804 90801	U1	90832 90791	U1	Yes No
Rehabilitative Services for Youth	90804		90832		Yes
Division of Child and Family Services	90801		90792		No

XII. Rehabilitative Services for Persons with Mental Illness (RSPMI)

The following 2013 CPT® procedure codes are payable to Rehabilitative Services for Persons with Mental Illness (RSPMI) providers. If the 2013 deleted code required prior authorization, the replacement code will require prior authorization. Please see Section II of this notice for information on requesting prior authorization from ValueOptions.

2013 Deleted Code	2013 Replacement Code
90801 HA, U1 Mental Health Evaluation/Diagnosis	**90791 HA, U1** Mental Health Evaluation/Diagnosis
90801 U7 Mental Health Evaluation/Diagnosis – Telemedicine	**90791 U7** Mental Health Evaluation/Diagnosis – Telemedicine
T1023 HA, U1 Psychiatric Diagnostic Assessment – Initial	**90792 HA, U1** Psychiatric Diagnostic Assessment – Initial
T1023 U7 Psychiatric Diagnostic Assessment – Initial – Telemedicine	**90792 U7** Psychiatric Diagnostic Assessment – Initial – Telemedicine
T1023 HA, U2 Psychiatric Diagnostic Assessment – Continuing Care	**90792 HA, U2** Psychiatric Diagnostic Assessment – Continuing Care
T1023 – U7, U1 Psychiatric Diagnostic Assessment – Continuing Care – Telemedicine	**90792 – U7, U1** Psychiatric Diagnostic Assessment – Continuing Care – Telemedicine
90862 HA, HQ Group Outpatient – Pharmacologic Management by Physician	**H0034 HA, HQ** Group Outpatient – Pharmacologic Management by Physician
90862 HA Pharmacologic Management by Physician for Ages Under 21	**Use Appropriate E/M Code** 99212 HA, UB; 99213 HA, UB; 99214 HA, UB
90862 Pharmacologic Management by Physician for Ages 21 and Above	
90862 U7 Pharmacologic Management by Physician - Telemedicine	
90862 HA, UB Pharmacologic Management by Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Practice Nurse Practitioner	**Use Appropriate E/M Code** 99212 HA, SA; 99213 HA, SA; 99214 HA, SA

XIII. School-Based Mental Health Services (SBMH)

The following 2013 CPT® procedure code is payable to the School-Based Mental Health Program.

2013 Deleted Code	2013 Replacement Code
90801	90791

XIV. Vaccine Information

CPT® procedure code **90672**, influenza virus vaccine, live, for intranasal use, is payable to providers indicated in the table below with the following special criteria and billing instructions.

Coverage is limited to healthy individuals ages 2 through 49 who are not pregnant.

Procedure Code	Required Modifiers	Age Restriction in Years	Special Instructions
90672	TJ	Ages 2y-18y	Covered for ARKids First-B providers under the Vaccines for Children (VFC) program.
90672	EP TJ	Ages 2y-18y	Covered for ARKids First-A providers under the Vaccines for Children (VFC) program.
90672		Ages 19y-49y	Covered for Arkansas Department of Health, Outpatient Hospital and Physician providers.
90672		Ages 19y-49y	Covered for Nurse Practitioner providers.
90672		Ages 21y-49y	Covered for Pharmacy providers.

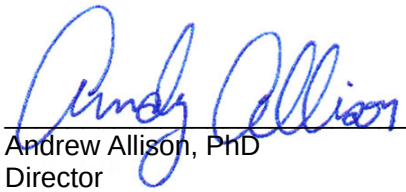
XV. Miscellaneous Information

Outpatient facilities billing payable CPT® codes in the range of **29000-29799** are required to bill on paper with attachments that document the procedure billed.

If you have questions regarding this notice, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.



Andrew Allison, PhD
Director

REQUEST FOR MOLECULAR PATHOLOGY LABORATORY SERVICES

Arkansas Foundation for Medical Care, Inc.
Attn: Molecular Pathology Review

P O Box 180001
Fort Smith, AR 72918-0001
Fax: (479) 649-9413

DATE: ____/____/____

Important: If all required information is not completed, the form will be returned to the provider.

(1) **PERFORMING PROVIDER NAME**	(2) **PROVIDER ID#/TAXONOMY CODE**
(3) **MAILING ADDRESS**	(4) **GROUP PROVIDER ID #** (9 digits) __ __ __ __ __ __ __ __ __
CITY **STATE** **ZIP CODE**	
(5) **PERFORMING PROVIDER SIGNATURE & CREDENTIALS**	

(6) **BENEFICIARY NAME [LAST]** **[FIRST]** **[M.I.]**	
(7) **ADDRESS** **CITY** **STATE** **ZIP CODE**	
(8) **MEDICAID BENEFICIARY ID** (10 digits) __ __ __ __ __ __ __ __ __ __	(9) **DOB MM/DD/YY** ____/____/_____ **SEX** _____

To file a Request for Molecular Pathology Laboratory Services, the following information is required:

							Request Disposition *Completed By AFMC*		
(10) SERVICE FROM DATE	(11) SERVICE TO DATE	(12) DIAGNOSIS CODE	*(13) DIAGNOSIS CODE DESCRIPTION*	(14) PROCEDURE CODE	(15) *PROCEDURE CODE DESCRIPTION*	(16) UNITS	***DECISION***		**DATE OF REVIEW**
							APPROVED	**DENIED**	

Molecular Pathology Request # _____
Completed by AFMC

Note: If applicable, attach copies of Medical Records/Supporting Documentation substantiating the medical necessity of requested services/procedures.
[Instructions for requesting molecular pathology and completion of this form are included on the reverse side of this form.]
Comments:

DMS-841 [3/15/13]

Requirements for Requests for Molecular Pathology Laboratory Services

Procedural Policy

To reduce delays in processing requests and to avoid returning requests due to incomplete and/or lack of documentation, the following procedures must be followed.

I. Requests for molecular pathology laboratory services must be requested and a prior authorization received prior to billing the claims.

II. The Request for Molecular Pathology Laboratory Services (Form DMS-841) must accompany the supporting clinical record when submitting a paper request.

III. Molecular Pathology Laboratory Services requests will be denied if received after the timely filing time frame (12 months beyond the date of service).

IV. AFMC Molecular Pathology Laboratory requests will be considered if all of the following documentation is received with the request.

A. All fields of form DMS-841 must be correctly completed by entering the following information:

(1) Enter performing provider's name.
(2) Enter the provider ID # and taxonomy code of performing provider.
(3) Enter the address the provider will use to receive correspondence regarding this request.
(4) If the provider is a member of a group, enter the group provider ID #.
(5) Performing provider's signature and credentials must be entered in this field.
(6) Enter the beneficiary's full name.
(7) Enter the beneficiary's complete address.
(8) Enter the beneficiary's Medicaid ID #.
(9) Enter the beneficiary's date of birth and sex.
(10) Enter the service from date.
(11) Enter the service to date.
(12) Enter the diagnosis code.
(13) Enter the diagnosis code description.
(14) Enter the procedure code and applicable modifier(s). (If there are more than 8 procedures, additional procedures must be added to a separate, completed form.)
(15) Enter the procedure code description.
(16) Enter the number of units.

B. Clinical records must:

1. Be legible and include records supporting the specific request.
2. Be signed by the performing provider.

C. Laboratory reports must include:

1. Clinical indication for lab
2. Signed orders for laboratory

D. Requests for reconsideration must be received within 30 calendar days of AFMC denial - only one reconsideration will be allowed.

E. AFMC reserves the right to request further clinical documentation as deemed necessary to complete a medical review.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **March 15, 2013**

SUBJECT: **Provider Manual Update Transmittal SecV-2-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
_	_	DMS-841	3-15-13

Explanation of Updates

Section V is updated to include form DMS-841, Request for Molecular Pathology Laboratory Services.

This transmittal and the enclosed form are for informational purposes only. **Please do not complete the enclosed form.**

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J400	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adverse Effects Form	DMS-2704

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485

Form Name	Form Link
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Assistance Dental Disposition	DMS-2635
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet
Quarterly Monitoring Form	AAS-9506
Referral for Audiology Services – School-Based Setting	DMS-7783
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634

Form Name	Form Link
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request for Molecular Pathology Laboratory Services	DMS-841
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2635
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-841
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit
Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit
Arkansas Department of Human Services, Children's Services

HP Enterprise Services Provider Assistance Center (PAC)

HP Enterprise Services Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

ICD-9-CM, CPT, and HCPCS Reference Book Ordering

Immunizations Registry Help Desk

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

QSource of Arkansas

Select Optical

Standard Register

Table of Desirable Weights

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

REQUEST FOR MOLECULAR PATHOLOGY LABORATORY SERVICES

Arkansas Foundation for Medical Care, Inc.
Attn: Molecular Pathology Review
P O Box 180001 **DATE: ____/____/____**
Fort Smith, AR 72918-0001
Fax: (479) 649-9413

Important: If all required information is not completed, the form will be returned to the provider.

(1) **PERFORMING PROVIDER NAME**	(2) **PROVIDER ID#/TAXONOMY CODE**
(3) **MAILING ADDRESS**	(4) **GROUP PROVIDER ID #** (9 digits) ___ ___ ___ ___ ___ ___ ___ ___ ___
CITY **STATE** **ZIP CODE**	
(5) **PERFORMING PROVIDER SIGNATURE & CREDENTIALS**	

(6) **BENEFICIARY NAME [LAST] [FIRST] [M.I.]**	
(7) **ADDRESS**	**CITY** **STATE** **ZIP CODE**
(8) **MEDICAID BENEFICIARY ID** (10 digits) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	(9) **DOB MM/DD/YY** **SEX** ____/____/_____ _____

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